Central West **LHIN**
RLISS du Centre-Ouest

Integrated Health Services Plan 3

2013-2016

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Next »

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Executive Summary

The Central West LHIN presents the third Integrated Health Services Plan (IHSP 3). The IHSP 3 was developed in consultation with community members and Health Service Providers. This strategic document lays out the LHIN's plans to improve local health care. It is for the period April 2013 to March 2016.

The IHSP 3 aligns with *Ontario's Action Plan for Health Care*, in which the province set actions to build a health system that is more responsive to residents requiring health care services, and delivers improving quality of care and value for money.

The IHSP 3 describes strategic directions which outline how the LHIN will focus its efforts over the next three years to ensure that the right services are available at the right place and at the right time, tailored to meet local needs.

The IHSP 3 includes more specific initiatives that the LHIN will undertake to give meaning to these strategic directions. Furthermore, the IHSP presents metrics that indicate how the LHIN will measure its success.

The Central West LHIN is home to 6.2% of the population of Ontario and continues to grow at one of the fastest rates in the province. It is one of the most ethno-culturally diverse regions in Ontario. In recognition of the diversity of the communities in the Central West LHIN and individuals' experiences with the local health care system, attention will continue to be focused on Diversity and Health Equity.

The population is relatively healthy. Seniors comprise about 11% of the population. There are a number of health indicators that suggest attention is needed, particularly in access to primary care, diabetes services, mental health and substance abuse programs, and services for seniors. Understanding the needs of individuals who have complex needs and are high users of health care services provides information that is required to improve the delivery of health services and, importantly, to build capacity to meet the needs of these individuals.

Over the past number of years the Central West LHIN has achieved a number of successes in improving access to care and the integration of services, working in partnership with local Health Service Providers to improve the capacity and quality of services.

Though facing rapid population growth, wait times in Emergency Departments in hospitals in the Central West LHIN continue to improve. The Central West LHIN is a top

performer maintaining one of the lowest numbers of Alternate Level of Care days in the province. Wait times for diagnostic services such as MRIs and CT scans are improving. Surgical wait times continue to need attention.

The Central West LHIN undertook an extensive community engagement process to ensure LHIN Board members and staff heard members of the community and the Health Service Providers that it funds, and with which it has accountability agreements. The LHIN Board members and staff confirmed the LHIN's mission, vision and values and criteria to determine the strategic directions and initiatives to be incorporated in the IHSP.

Strategic Directions

Over the next three years, the Central West LHIN will focus its time and attention on four strategic directions: ***Improve Access to Care, Streamline Transitions and Navigation of the System, Drive Quality and Value, and Build on the Momentum.*** Initiatives that will be undertaken by the LHIN are identified for each strategic direction.

I. Improve Access to Care

i. Improve access to Primary Health/Family Health Care
ii. Improve access to chronic disease prevention & management programs, with an emphasis on diabetes
iii. Improve access to mental health and substance abuse services, with a focus on youth
iv. Improve access to community-based services for seniors

II. Streamline Transitions and Navigation of the System

i. Improve linkages with and among Primary / Family Health Care and other providers in the health care system
ii. Improve system navigation resources
iii. Increase system collaboration through use of information technologies

III. Drive Quality and Value

i. Ensure an overarching LHIN quality framework
ii. Optimize use of health care resources to foster better value

IV. Build on the Momentum

i. Aboriginal Health
ii. Diversity and Health Equity
iii. French Language Services
iv. Palliative Care
v. Women and Children's Health

Following the development of the IHSP, the LHIN will ensure that there is on-going communication of the work the LHIN is undertaking and its efforts to improve access, integration and the performance of the local health care system.

Section A

Today's Health Care Environment

Established by the Ontario government in March 2006, Local Health Integration Networks (LHINs) are not-for-profit corporations that work with local health providers and community members to determine health service priorities for specific geographic areas. LHINs plan, integrate and fund local health services.

It is important to distinguish between the LHIN *as a geographic region*, made up of residents, community partners and Health Service Providers (HSPs), and the LHIN *as a corporate entity* – the Board members and staff who oversee local health care services. For the purposes of this document, "Central West LHIN" should be understood to be the geographical region of the many Health Service Providers, community partners and the LHIN, working together to improve the health of the residents in the LHIN.

Why LHINs?

Prior to the formation of LHINs, health care services in Ontario were fragmented. Many Health Service Providers delivered care in isolation. Clients of health care services, and their loved ones, were required to make their own way through a very complex health system as they moved from one provider to another. LHINs were created to change all that.

In March 2006, the *Local Health System Integration Act* transformed the way Ontario's health care system is managed. While LHINs do not provide services, the LHINs' mandate is to plan, integrate and fund health care services.

Ontario's LHINs are responsible for the allocation of about half of the province's health care expenditures, or about $22 billion in funding in 2011[1]. Working with the Ministry of Health and Long-Term Care, LHINs will ensure that local and regional plans align with provincial priorities for the health care system to improve access to care and ensure system sustainability.

[1] Estimates, 11/12

Planning for Tomorrow's Care, Today

An aging population is an important factor in driving future health care costs. Today's health care system must prepare for the demographic shift that will see double the number of seniors living in Ontario over the next 20 years. The cost of care for a senior is three times higher than for the average person. Health system planners – like those at the LHIN – will need to think about tomorrow's health care, today. The ability to plan for the next 20 years will play a key factor in the sustainability of the province's health care system. Consider that Ontario will have 43% more seniors by 2022 and 50% more by 2032[2]. Without changing how care is delivered in Ontario, the health care system could cost a staggering $24 billion dollars more per year by 2032[3].

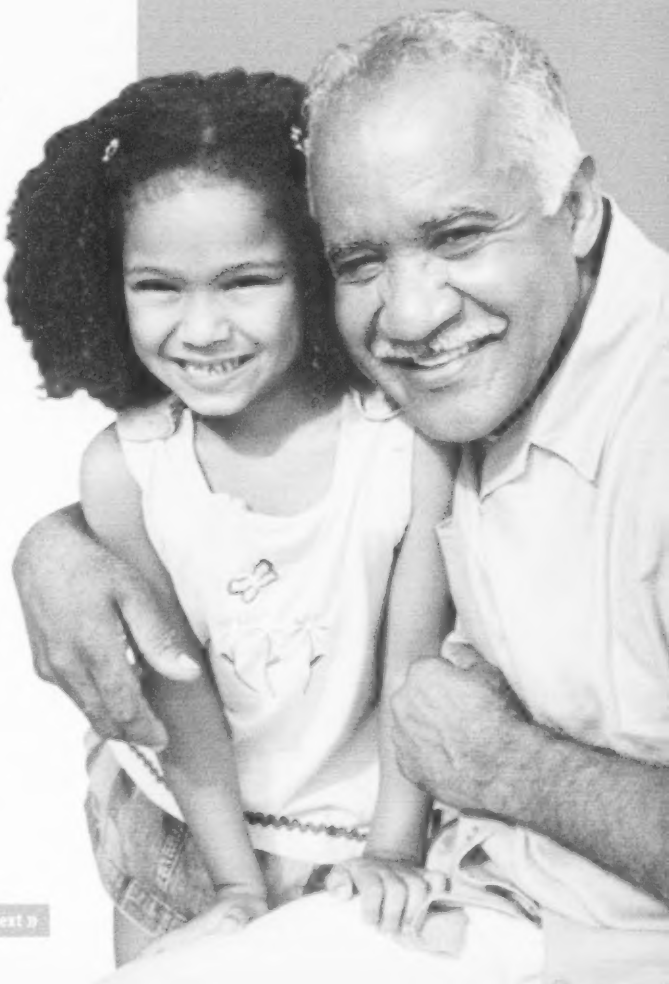
Together, LHINs work to create *"a local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren."*

A critical focus of the Central West Local Health Integration Network (LHIN) is leading the development of an integrated system of health services that will improve access to services for all residents. While the LHIN undertakes many initiatives which support access to care, every three years the LHIN develops an Integrated Health Services Plan.

The **Integrated Health Service Plan (IHSP)** describes the LHIN's strategic directions. It includes specific initiatives that implement the strategic directions and metrics that measure the LHIN's performance. The IHSP does not detail every initiative the LHIN will undertake over the next three years. It is the LHIN's "strategic plan". It outlines how the LHIN intends to strategically focus its efforts to ensure that the right services are available at the right place at the right time, tailored to meet local needs.

Two other significant documents are companions to the Integrated Health Services Plan – The Annual Business Plan and The Annual Report. With the IHSP being a three year document, every year Central West LHIN develops an **Annual Business Plan** that outlines how the LHIN will implement the strategic directions and initiatives, and how it will measure the LHIN's performance in the year. The **Annual Report** looks back on the work done in the previous year, reporting on the LHIN's achievements. All these documents are posted on the Central West LHIN's website: **www.centralwestlhin.on.ca.**

Ontario will have **43% more** seniors by 2022 and **50% more** by 2032.



[2] Ontario's Action Plan for Health Care, p.7
[3] Ontario's Action Plan for Health Care, p.7

Alignment with Provincial Directions

While the LHIN is mandated to develop local integrated systems of health care, all LHINs in Ontario align their work to provincial directions. For the Integrated Health Services Plan that will span 2013-2016 (IHSP 3), this means that the Central West LHIN, like other LHINs, will align its work to *Ontario's Action Plan for Health Care*, launched by the Minister of Health and Long-Term Care in January, 2012. Additionally, leaders from all 14 LHINs came together to examine the province's health priorities and develop pan-LHIN system imperatives.

Ontario's Action Plan for Health Care

The reality of fiscal restraint, coupled with a growing and aging population, were key drivers in the development of *Ontario's Action Plan for Health Care*.

The *Action Plan* addresses how the Government and its partners will manage the growth in health care spending while continuing to provide high-quality care to all Ontarians. Ontario's *Action Plan* suggests that Ontario needs a patient-centred system that better integrates health providers – such as family health care, community care, hospitals and long-term care – that moves patients more seamlessly from one care setting to another [1]. Under this goal, the *Action Plan* identifies three areas of focus.

1. Keeping Ontario Healthy

The *Action Plan* focuses on helping people stay healthy by supporting the habits and lifestyle changes that keep people healthy in the first place. In addition to tackling childhood obesity, smoking and cancer screening, the province will continue to work on better management of chronic conditions, such as diabetes. LHINs across Ontario have been working with local providers on chronic disease prevention and management strategies for many years and a strong foundation is in place on which to build.

2. Faster Access and a Stronger Link to Family Health Care

Family health care is the hub of the health care system for most people. Family physicians (or a primary health care team) are ideally the first point of contact with the health care system when someone needs medical attention, unless it is an emergency. Outside of the hospital, the family physicians also provide follow-up care and refer patients to more specialized professionals. *Ontario's Action Plan* identifies faster access to primary care, more ways to gain access to family health care resources, and the introduction of quality measures to family health care, as key components of a fully integrated system. The goal is to ensure appropriate care from family care providers, to deliver right care in the right place at the right time, and to help reduce hospital admissions.

3. Right Care, Right Time, Right Place

- **The *Right Care*** means care informed by the best scientific evidence and clinical guidelines determined to be the best care for individuals requiring care. It eliminates unnecessary procedures and tests, freeing up health care resources for

[1] Ontario's Action Plan for Health Care, p.5

those who need them most. The Province and the LHINs will work with Health Quality Ontario to turn new clinical evidence into tools and guidelines that can help providers make decisions that are client-centred and evidence-based.

- **Care *at the Right Time*** means having access to the care people need when they need it. This could mean supports to help individuals stay at home longer, in their communities, and close to family and friends. This focus also means a renewed emphasis on preventative and proactive care so chronic conditions are managed proactively, reducing the number of hospitalizations a person will require and easing the strain in emergency rooms and inpatient beds across the province.
- **Care *in the Right Place*** addresses several serious issues in the health care system. One of the most pressing is the challenge of Alternate Level of Care" (or ALC) patients – those patients who are in hospital beds, but would be better cared for in other locations, such as in the community with support services. Community care costs a fraction of what it costs to keep a patient in a hospital bed, and receiving care at home is often preferable for the patient. To support the *Action Plan's* goal of providing more community-based care for seniors, the 2012 provincial budget will increase funding for home and community service by four percent annually over the next three years [3].

Pan-LHIN System Imperatives

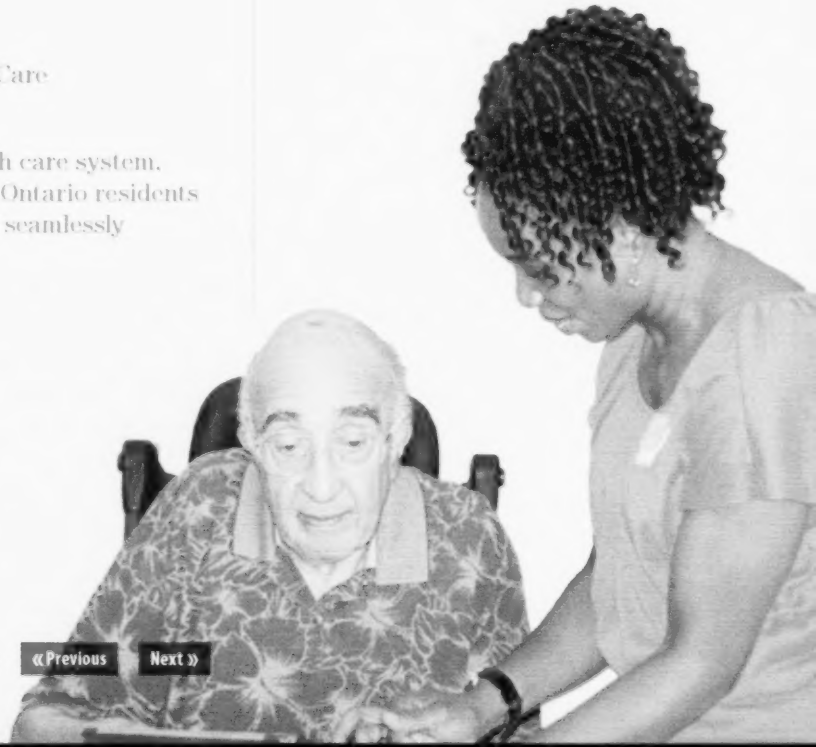
Across Ontario, LHINs recognized the value of focusing their collective efforts. For this reason, and to align the high-level goals of the Action Plan with the Health Service Providers, Ontario's LHINs have developed pan-LHIN system *imperatives*. These imperatives include:

- Leading with Quality and Safety
- Enhancing Access to Primary Care
- Enhancing Coordination and Transitions of Care
- Holding the Gains

LHINs will work actively to integrate the health care system. Integrating the health care system means that Ontario residents will be assisted in finding care more easily and seamlessly transition between different care providers.

Focus on Quality

In April, 2012, LHINs agreed that LHINs will enhance efforts to improve the delivery of high quality care in Ontario. As a result, LHINs agreed to adopt the Quality Framework developed by Health Quality Ontario. The framework provides a structure for focusing efforts of all LHINs on quality.



[3] 2012 Ontario Budget, p.28

Section B

Planning for the Needs of the Central West LHIN

The Central West LHIN encompasses all of Dufferin County, the northern portion of Peel Region, parts of north-west Toronto, and south-west York Region. It includes Brampton, Caledon, Dufferin County, Etobicoke-Rexdale, Mississauga-Malton, and Vaughan-Woodbridge.

Like other LHINs in Ontario, the Central West LHIN was founded on the principle that *local health care is best planned and funded in a coordinated way locally, because local people best know their own health service needs and priorities.* The Central West LHIN's goal is to develop an integrated system of health services aimed at improving access to the right services in the right place at the right time.

Under the *Local Health System Integration Act* (LHSIA), the Central West LHIN has the authority to plan, coordinate, integrate, fund and also monitor the local health system for the purpose of improving the health of residents who live within the LHIN's geographic boundaries.

Based on this mandate, the Central West LHIN established its strategic directions using five guiding principles:

1. **Equitable access** based on patient / client need
2. Preservation of **patients / clients' choice**
3. **People-centered,** community-focused care that responds to local population health needs
4. **Measurable, results-driven outcomes** based on strategic policy formulation, business planning and information management
5. **Shared accountability** among providers, government, community and citizens

Central West LHIN

As indicated, the IHSP is aligned with the Provincial Government's *Action Plan for Health Care*. Health Service Providers then, in turn, align their strategic plans with the Integrated Health Services Plan. The IHSP ensures time and resources are focused strategically. Health systems are complex and have many competing requirements and the IHSP ensures that the LHIN directs its energy toward the initiatives that will best serve the residents of the LHIN.

The LHIN's Vision

A local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren.

Section C

Current Context and Planning Within Central West LHIN

Services from Birth to End-of-Life: The Central West LHIN is home to an array of Health Service Providers.

Providing services from birth until end-of-life, Health Service Providers in Central West LHIN include:

- Community Health Centres
- Community Care Access Centre
- Hospitals
- Mental Health and Addictions Services
- Long-Term Care Homes
- Community Support Services.

Achievements

Over the past several years, the LHIN has worked diligently, in collaboration with Health Service Providers, to realize the vision of *a local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren*. The following recent achievements highlight the success of this work.

Access to Care: The Central West LHIN has worked diligently to improve access to care. Examples include:

- The Central West LHIN played the pivotal role locally to roll out Behavioural Supports Ontario – BSO, an initiative aimed at enhancing services for elderly persons with complex behaviours due to dementia, mental health or other neurological conditions.
- Clients of community mental health and addiction services have greater access to psychiatrists and family doctors through psychiatric sessionals for case consultation and staff education. In the last three years, over 30 full-time

positions have been added to frontline care for mental health and addictions and mental health and addiction services investments increased by almost $11.5M since 2007.
- Assess and Restore additions to Headwaters Health Care Centre and William Osler Health System have created new capacity for seniors who require additional time to recover before going home or beginning rehabilitation services.
- William Osler Health System has redesigned its stroke program at their Brampton Memorial Hospital site to group stroke patients and implement best practices.
- The Geriatric Outreach Program supports seniors in multiple care locations.
- The Nurse Practitioner Outreach Program assists Long-Term Care homes in managing ill residents who may otherwise be sent to the Emergency Department.
- Transportation services by Caledon Community Services, CANES Community Care and Dufferin County Community Support Services that support seniors to attend day programs, be seen by Physicians and participate in activities that support their capacity to remain in their homes.
- Programs to provide home making and home maintenance to support seniors in their homes.

Integration: The Central West LHIN has focused its work on improving integration. Specific achievements include:

- Fostering communities of practice through the Central West LHIN Palliative Care Network, Concurrent Disorder Network, Mental Health and Addictions Systems Integration Project and Regional Renal Coordinating Centre and the Centre for Complex Diabetes Care.
- Continuing the dialogue, collaborative planning and collective action with providers through Core Action Groups – Diversity and Health Equity, French Language Services, Mental Health and Addiction Services, Services for Seniors, and Women and Children's Health.
- Supporting the adoption of the Physician Electronic Medical Record and Connecting GTA as two examples of work to reduce duplication and improve integration of information.
- Community mental health and community support service providers have fully implemented the Community Care Information Management Common Assessment and Integrated Assessment Record initiatives which support Health Service Providers to develop and securely share client information (with consent).
- Supporting the use of Advance Practice Nurses to coordinate Palliative Care among providers.
- A memorandum of understanding between Headwaters Health Care Centre and William Osler Health System to support Orthopedic Care and streamline the total joint replacement

Mental Health and Addictions

Jason Dulac remembers a time when he couldn't speak in front of a crowd. Today, the 23-year old is the Board Chair for Friends and Advocates Peel, an organization that provides social rehabilitation and peer support for people who are recovering from a mental illness.

"Lots of people suffer from some form of mental illness and are unable to fit into society," he says. "Friends and Advocates helps you get back into the community, because you can't get better on your own."

Friends and Advocates Peel is one of the community programs funded by the Central West LHIN.

Somali Community Engagement

In spring 2011, the Central West LHIN held a community engagement session with the Somali community that drew over 80 participants. Members of the Somali community from the Rexdale / Dixon area as well as MPPs and representatives from the Health Service Providers filled the Kingsview Village Junior School's gymnasium to discuss residents' health care needs.

One attendee was simply happy to be asked. "16 years I've been here. No one asked about our health needs before – first time today."

process for people from Dufferin.
- Supporting the expanded role of Central West Community Care Access Centre to centralize access to care through assessment and placement to adult day programs and assisted living programs.

Diversity and Health Equity: In recognition of the diversity of the communities in the Central West LHIN and individuals' experiences with the local health care system, the Central West LHIN and local Health Service Providers have focused on Diversity and Health Equity. Achievements include:

- In 2009, the Central West LHIN established the Diversity and Health Equity Core Action Group, comprised of representatives from local Health Service Provider organizations, which has worked to identify specific local strategies to promote culturally-competent health care services and ensure equitable access to care.
- In partnership with the Diversity and Health Equity Core Action Group, the LHIN developed and conducted a Health Equity Environmental Scan. This assisted Health Service Providers to identify the status of their work in health equity and set the foundation from which organizations can develop individual health equity plans. Information was also used to inform the key priorities for the Core Action Group to focus on moving forward.
- The LHIN, in partnership with the Ministry of Health and Long-Term Care, is implementing the Health Equity Impact Assessment Tool (HEIA), a flexible and practical assessment tool that can be used to identify potential health impacts (positive or negative) of a plan, policy or program on vulnerable or disadvantaged groups within the general population. LHIN staff and the Diversity and Equity Core Action Group have been trained on the tool.

Measuring Performance

The Central West LHIN continues to work with Health Service Providers to improve existing services and to implement new services. Some of these include:

- Decreasing Emergency Department (ED) wait times
- Reducing the time people spend waiting for surgery and diagnostic imaging
- Reducing the amount of time patients who no longer require the services of hospital inpatient beds (designated as Alterative Level of Care or ALC) wait in the hospital before being

discharged safely to appropriate care.

The Central West LHIN is accountable to the Ministry of Health and Long Term Care through the Ministry LHIN Performance Agreement (MLPA), a document which sets out annual LHIN targeted performance in 14 patient/client areas and quality indicators.

Emergency Room Length of Stay and Alternative Level of Care

The Central West LHIN is committed to improving both the efficiency and the quality of care for residents who require emergency services. The Central West LHIN serves a rapidly growing population dispersed over a wide geography, from rural to urban. It is home to three hospital sites, including one of the busiest Emergency Departments in the province at the Brampton Civic Hospital.

Emergency Department patients in the Central West LHIN have a consistently lower proportion of low acuity (less urgent) patients. The average percentage of low acuity visits is 28% in the Central West LHIN compared to 40% in the province. Fewer low acuity visits free up vital emergency resources for higher acuity patients. There are many factors contributing to this success, including the establishment of an Urgent Care Clinic at the Brampton Civic Hospital which provides an alternative and more appropriate destination for patients with urgent, but non-emergent, needs.

The Central West LHIN has invested in services targeting the care needs unique to the population. For example, approximately 25% of the ED visits in Central West LHIN are pediatric patients. This has prompted an investment in a Pediatric Assessment Zone in the Emergency Department for both Brampton Civic Hospital and Etobicoke General Hospital, in which staff have specialized training and education to improve a pediatric friendly environment. Additionally, the hospital has implemented a Cardiac Assessment Zone designed to manage ambulatory patients with chest pain, one of the largest reasons for Emergency Department visits in Brampton. Approximately 6 out of 10 patients who are cared for through the Pediatric Assessment Zone and Cardiac Assessment Zone are meeting length of stay targets, which means they are waiting within a reasonable time frame while they are receiving specialized and high-quality care.

Through targeted investments, such as those mentioned above, significant improvements have been made to length of stay indicators in the Ministry LHIN Performance Agreement.

Working together to serve a growing population

Based on the 2011 census, the Central West LHIN population has increased by 27% since 2001. This LHIN is one of the fastest growing in the province and is expected to grow by another 20% in the next 10 years. This rapidly growing population means that even though the rate of Emergency Department visits is steady, the volume has increased. Between 2008 and 2012, the Emergency Department volumes across the province have increased by 11%. In that same period, volumes in the Central West LHIN have increased by 22%, double the provincial increase.

Diabetes

Local family physician Dr. Sanjeev Goel is playing an important role in improving diabetes care in the Central West LHIN. He is working to ensure a more integrated health system for residents living with diabetes in the communities in the Central West LHIN.

"Over 10 % of the population has diabetes," he says. "It's increasing in older adults and we're also seeing younger cases than before."

An ideal integrated system would support patients to move through the health care process where providers would already have access to their information. For example, if a patient visits the ER for high blood sugar, their history would be accessible to the emergency room staff so they're aware of medications and treatment would not be duplicated.

Reduction in Length of Emergency Department Visits for High Acuity (Very Sick) Patients Who Are Not Admitted to Hospital Inpatient Beds

The provincial standard (best practice) for the total length of stay (from triage to leaving the Emergency Department) for these patients is 8 hours. These patients are very sick, and may require diagnostic imaging services, blood tests or even require a period of observation – all of which is completed in 8 hours or less. In the Central West LHIN, actual performance for 9 out of 10 non-admitted high acuity patients has improved consistently over the past four years.

Reduction in Length of Emergency Department Visits for Low Acuity Patients

There is a concerted effort to evaluate, treat, and discharge patients as efficiently as possible, including low acuity patients. There are fewer patients with minor or uncomplicated conditions patients in Emergency Departments in the Central West LHIN than in other LHINs. The provincial standard for these patients is 4 hours. In the Central West LHIN, performance has improved from 4.3 hours in 2010/11, to 4.0 hours in 2011/12, to 3.4 hours for the first half of 2012/13.

Reduction in Emergency Department Length of Stay for Patients Admitted to Hospital Inpatient Beds

The provincial target for these patients is 25 hours, and the Central West LHIN 2012/13 Ministry LHIN Performance Agreement target is 30.6 hours. Performance in this indicator varies substantially with the number of patients occupying inpatient beds already–the more inpatient beds are occupied, the longer patients in the Emergency Department will have to wait for one. Substantial coordination between Emergency Department staff and other medical staff within the hospital, and between hospital staff and community support agencies, is required to manage this measure.

Alternate Level of Care (ALC)

The Central West LHIN is a top performer in the Alternate Level of Care (ALC) indicator. Over several years, the Central West LHIN has maintained one of the lowest numbers of ALC days in the province. This means that patients who no longer require acute care in the hospital are able to transition to the next most appropriate step in their individual care plans with the necessary supports in place.

Surgical and Diagnostic Wait Times

Funding, monitoring and improving the wait times for key surgeries and diagnostic services are an important function of the Central West LHIN. Each year the LHIN works with local Health Service Providers and the Ministry of Health and Long-Term Care to reduce wait times in the Central West LHIN. The LHIN monitors 6 key surgical and diagnostic wait times including: cancer, cataract, hip replacement and knee replacement surgeries and diagnostic MRI and CT Scans.

Over the past few years, the Central West LHIN has seen a significant increase in referrals for surgeries such as cataract, and hip and knee replacement, which has increased wait times for these surgeries. Overall, hospitals in the Central West LHIN have exceeded annual allocated surgical volumes each year which means they are performing more surgeries and diagnostic imaging services than budgeted. The LHIN has been successful in supporting local hospitals to secure additional funds to perform more surgeries and diagnostic imagining services over the past few years. The Central West LHIN wait times for CT scans are among the shortest in the province.

Mental Health and Substance Abuse

Repeat emergency visits for mental health and substance abuse have been added to the performance measures for all LHINs. Over the past few years the LHIN and local Health Service Providers, both hospitals and community-based, have worked together to improve care for individuals with mental health and substance abuse issues. Through the use of Hospital Service Accountability Agreements, the LHIN facilitated a memorandum of understanding between Headwaters Health Care Centre and William Osler Health System to ensure patients across the LHIN receive improved access to community and hospital mental health and addictions services.

Adult Day Program

A friend told 81-year old Kareena Baksh about the India Rainbow Adult Day Program. Since then, the program has become part of her weekly routine.

Before she joined the program, Kareena says she was physically weak. "I had trouble walking," she says. She was also feeling lonely because even though she lives with her family, their time was limited. "There was no one to talk to, everyone was busy," she explains.

But since joining India Rainbow, her situation has greatly improved. "I can walk better!" she says. The six-minute walking program at the centre has given Kareena the confidence and strength to be more mobile.

Through Aging at Home funding the Central West LHIN was able to expand support for Adult Day Programs.

In 2010, the Ministry of Health and Long-Term Care introduced the *Excellent Care for All Act* that puts people first by improving the quality and value of the patient experience through the application of evidence-based practices.

Access to Community Care

Over the past few years, the Central West LHIN has maintained strong performance in the Ministry LHIN Performance Agreement indicator measuring the wait time for Central West Community Care Access Centre (CCAC) in-home services. In 2011/12, the LHIN was never more than 3 days away from its target of 19 days, providing service 30% faster than the provincial rate.

The CCAC has maintained a very good wait time despite the increasing number of referrals from the hospital and community over the past 3 years. The Central West LHIN has invested in community services across all sectors to assist the Central West CCAC in managing high acuity clients (those most sick and in need of home care services). The Central West LHIN will continue to invest in the community to ensure that residents have access to community care when they need it.

Excellent Care for All

In 2010, the Ministry of Health and Long-Term Care introduced the Excellent Care for All Act that puts people first by improving the quality and value of the patient experience through the application of evidence-based practices. A key indicator used to measure quality of care in hospitals is the readmission rate within 30 days for patients who have been treated for selected types of cases, for example diabetes and congestive heart failure.

Recent reports show the Central West LHIN is doing well in reducing avoidable admissions to the hospital. Readmission rates for diabetes related conditions are improving. A major priority of the LHIN is to improve self-management of diabetes through diabetes education programs and primary care intervention – and there have already been major improvements. The Central West LHIN will continue to work with local Health Service Providers to meet the needs of the community, bearing in mind the rapid population growth, the aging of the population, and the capacity of Health Service Providers.

More Progress to Come

As the IHSP 3 and its strategic directions were established, the Central West LHIN tied initiatives in the IHSP 3 to improvements in the Ministry LHIN Performance Agreement indicators. These indicators are system-level measures of how well the LHIN and local Health Service Providers are addressing the needs of local residents.

Additionally, the LHIN is looking beyond the Ministry LHIN Performance Agreement indicators and will establish a local quality framework to improve treatment, care and safety based on leading practices, while building capacity for improvement and safety.

How Did the LHIN Identify its Strategic Directions?

Developing the IHSP 3 is a complex undertaking. The LHIN took a careful approach to ensure an innovative, strategic and thoughtful plan. The LHIN used distinct, but equally important, Planning Principles and Evaluation Criteria.

Planning Principles are essentially corporate planning beliefs that underpin the LHIN's thinking during planning. These are at the core of the Integrated Health Services Plan. The planning principles were consistent with those used in the initial IHSP and the second IHSP, with a strong sense of renewal and an additional emphasis on quality.

These Planning Principles are:

- Equitable access based on patient/client need
- Preservation of patients'/clients' choice
- People-centered, community-focused care that responds to local health needs
- Measurable, results-driven outcomes based on strategic policy formulation, quality, business planning and information management
- Shared accountability between providers, government, community and citizens.

How Did the LHIN Distinguish Among Options to be Identified as Strategic Directions?

Evaluation criteria are tools used to determine priorities. Because the LHIN has to focus its efforts strategically (it has limited time and resources), the LHIN needed a mechanism to determine its strategic directions. The criteria used by the LHIN assisted with making choices about where the LHIN would focus its energy over the next three years.

Supported by principles and criteria, the LHIN established an engagement process to support the development of the IHSP 3. This process was designed to ensure that the voices, perspectives and opinions of community members, Health Service Providers, and Board members and staff of the Central West LHIN, were gathered and considered. Attention was paid to engaging each stakeholder group in a meaningful way.

The Central West LHIN's Board of Directors developed its perspective about what an inspired future for the Central West LHIN might look like and outlined strategic directions to be included in the Integrated Health Services Plan. These perspectives were then 'tested'.

Putting it all Together to Develop the IHSP 3

The IHSP 3 has been developed to:

1. Align with the Local Health System Integration Act
2. Align with Ontario's Action Plan for Health Care
3. Support the Central West LHIN's Vision, Mandate and Values
4. Align with the work of other LHINs
5. Address local needs and current pressing health issues
6. Engage the local community, including members of the public and Health Service Providers
7. Meet Ministry of Health and Long-Term Care requirements for performance

Developing an integrated system of health services aimed at improving access to the right care at the right time is no small undertaking. It will take the concerted, coordinated efforts of many – the LHIN Board and Staff and community members and Health Service Providers.

Evaluation Criteria

- Strategic Fit: alignment with IHSP, provider system role (mandate and capacity)
- Population Health: contribution towards improvements in local health status, relevance, health promotion/prevention
- System Values: contribution towards fulfilling client-focus, partnerships, engagement, innovation, equity and operational efficiency
- System Performance: contribution toward improvements in access, quality , sustainability and integration

A total of 14 community engagement sessions were held between June and October of 2012 across the LHIN. In the first series of sessions in June, LHIN Board members and staff presented a series of options about strategic directions that could be included in the Integrated Health Services Plan. Feedback was solicited through open conversations and through workbooks with targeted questions that were collected and analyzed. This information was integrated into the planning process. These sessions provided the opportunity for community members to add to the work being undertaken by the LHIN.

In the second series of sessions in late September and early October, LHIN Board members and staff presented the draft strategic directions to be included in the IHSP 3, based on the sessions in June, and sought validation by those in attendance. This IHSP document well reflects the feedback and input of community members as expressed at these sessions.

The Central West LHIN also sought the views of local Health Service Providers. The LHIN held Governance to Governance (G2G) sessions with LHIN Board members and senior staff and members of Boards and senior leaders of Health Service Providers. Like the community sessions, the LHIN held two sessions, one in June and one in early October to present and validate strategic directions and sought Health Service Providers' perspectives about what an inspired future state might look like.

During the process, LHIN staff also met with client groups at local Health Service Providers and with community groups to share the developing strategic directions of the LHIN's third IHSP. Individuals provided their feedback, shared their experiences and expressed their views about the local health care system.

Section D

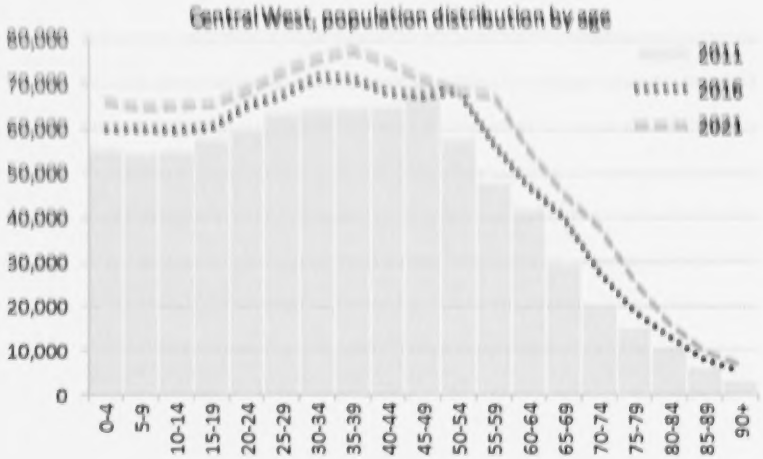
About the Central West LHIN

By understanding relationships and needs in the region and by listening to community members, the LHIN identifies important local issues and develops a keen understanding of the complex relationships and circumstances within the local health care system. This understanding supports the identification of priorities and corresponding actions.

To develop the IHSP 3, the LHIN took the time to review the region's demographic profile and listened carefully to feedback provided by patients, clients, families and providers. Below is a summary of what was learned.*

Higher Than Average Growth Rate

The Central West LHIN is home to 6.4% of the population of Ontario* and continues to grow. Between 2006 and 2011, the population in the Central West LHIN grew 11.2%, faster than Ontario's growth rate of 5.6%.



* Data included in this section has been provided by the LHIN Analytics Branch. Where discrepancies in the data provided exist, the data appearing in the Interpretation files has been used.

Languages Spoken Most at Home in the Central West LHIN (2011 Census)

1. English
2. Punjabi
3. Urdu
4. Gujarati
5. Tamil
6. Spanish
7. Hindi
8. Italian
9. Portuguese
10. Tagalog

The population in the Central West LHIN is predominantly urban, with 85.5% of residents residing in urban centres (communities with greater than 100,000 persons). In 2011, the vast majority of LHIN residents lived in a large urban centre including Brampton, Malton, Rexdale and Woodbridge (population of 100,000+), while 6.5% lived in rural areas.

The fastest growing age group is those over 75 years of age – at 36.3% growth rate, significantly higher than the Ontario average. This trend is expected to continue, with an additional 11% growth in the total population by 2016 and 46.7% growth by 2031.

The Central West LHIN is one of the most diverse communities in Ontario

The Central West LHIN has the highest proportion of visible minorities across all 14 LHINs, with over half of the people living in the LHIN being visible minorities (Ontario – a fifth of the population is visible minorities). 45.6% of Central West LHIN's population is newcomers (Ontario is 28.3%). Central West LHIN had the highest rate of recent newcomers (arrived within last 5 years), at 9.5% of the population.

Additionally, 58.1% of the Central West LHIN's population reported English as its mother tongue (second lowest in the province), and 1% of the population reported French as their mother tongue (lowest in the province). Four percent of Central West LHIN's population reported no knowledge of English or French, which was the second highest rate in the province.

There are challenges that must be addressed in communicating with all of the residents in the Central West LHIN – and opportunities to deepen the LHIN's relationships with local ethno-cultural communities.

Seniors comprise 11% of the population of the LHIN – but the percentage is increasing

The Central West LHIN has the lowest proportion of seniors of all LHINs with the population aged 65 and over comprising 11% of the population, compared with 14.2% as the average of other LHINs. It is expected that the proportion of seniors in the Central West LHIN will rise to 12.1% by 2016 and to 13.7% by 2021, though these projections still fall below the provincial proportion.

Seniors in the Central West LHIN appear to be healthier, with the highest life expectancy in Ontario. Additionally, the crude

mortality and projected years of life lost for seniors in the Central West LHIN are lower than the Ontario average.

New information suggests that 7,900 seniors aged 65+ (26.1%) currently suffer from dementia, the third lowest number in the province. This number is projected to rise to 12,000 individuals by 2020.

Mental Health & Substance Abuse

Facts to consider when planning for services:

- Central West LHIN residents make up roughly 4% of active cases, admissions and discharges in Ontario's psychiatric units
- Mood Disorders (40%) & Schizophrenia (38.5%) account for the largest patient populations
- Self-injury is the leading cause of potential years of life lost, though the rate is the lowest in the province
- The number of Emergency Department visits for Mental Health and Substance Abuse is increasing
- Community support wait times for Mental Health and Substance Abuse are longer than the Ontario average
- Residential treatment, community treatment, and initial assessment and treatment planning have very long average wait times for services offered in the LHIN
- Average wait times for case management, counselling and treatment, early intervention, diversion and court support, and support within housing were greater than elsewhere in the province.

Maternal Health

In 2009/10, 11,040 women from the Central West LHIN gave birth. Women giving birth in the Central West LHIN tend to be younger (highest proportion in 25-34 age category).

Central West LHIN and Complex, Acute Populations

As part of the IHSP3 planning, the Central West LHIN carried out an analysis to understand the distribution and characteristics of "high users" of hospital and homecare services. High users are patients who use a disproportionately large amount of hospital and homecare resources. A disproportionately large amount of resources translates into greater health care expenses.

There are a number of factors which may lead to patients being deemed high users. These include having a large number of health care events, and/ or having one or more expensive

Central West LHIN Facts

- 36% of residents have one chronic condition – 14% residents have multiple chronic conditions
- Diabetes is increasing – 11.4% is 3rd highest in Ontario
- Rate of growth in visits to a health care provider for Mental Health and Addictions 21.7% compared to an Ontario average of 13.9%
- Current population over 65 year is 41,435 – over 75 years is 30,659
- High birth rate – in Central West LHIN hospitals 7,808 – Central West LHIN women 11,049
- Most residents in the Central West LHIN have a doctor (92%)
- Highest life expectancy in Ontario
- Rates are *improving* for specific disease groups:
  - Rates for Chronic Obstructive Pulmonary Disorder (lung disease), heart disease and stroke are the lowest in Ontario
  - Mortality rates for arthritis, cancer, COPD, hypertension and Ischemic Heart Disease are the lowest in Ontario
  - Hospitalization rates for cancer are the lowest in Ontario
  - % of residents over the age of 75 with heart disease are lower than the Ontario average (20% versus 25%)
  - With the exception of arthritis, hospitalization rates for all chronic conditions are decreasing

High users are patients who use a disproportionately large amount of hospital and homecare resources. A disproportionately large amount of resources translates into greater health care expenses.

health care events, and/or having a long length of stay. Analysis has been undertaken on the top 10%, top 5%, and top 1% of patients accumulating the highest hospital and homecare costs. Understanding the needs of these patients provides information that the LHIN and Health Service Providers require to improve planning for the delivery of health services and, importantly, to build capacity to meet the needs of these individuals. Many of these individuals using hospital inpatient and emergency services have respiratory, circulatory and digestive system illnesses.

Information about "high users" includes:

- Brampton has one of the largest numbers of "high users" in Ontario – though the rate of high users per 1,000 population is lower than the provincial average.
- North Etobicoke has the highest rate of high users (28.9 per 1,000 population) in the LHIN, followed by Dufferin County (27.8 per 1,000 population), and Brampton (21.8 per 1,000 population).
- Seniors comprised about half of the high users population.
- The top 1% of high users accounted for 33% of ALC days.
- 83% of high users used a combination of care types in the hospital and homecare settings.

Home Care lower than the Ontario average

In 2010-11 there were 31,113 home care clients receiving care in the Central West LHIN comprising approximately 5% of Ontario's total home care clients. The rate of home care utilization in Central West LHIN is lower than the Ontario average and has remained relatively stable from 2007/08 to 2010/11. The rate of nursing visits per 1,000 in the Central West LHIN is the lowest rate in the province. Nursing visits account for the largest number of home care visits in the LHIN.

What is Central West LHIN's Projected Utilization and Demand for Services?

What will the demand for services be in Central West LHIN over the next three years? How will this differ from current demand? How will the LHIN and Health Service Providers plan to meet this new demand?

All services can be expected to face increasing demand over the next three years. The LHIN and Health Service Providers will plan how to best respond to meet the needs of the rapidly growing population in the Central West LHIN. And as the population ages, it is likely that more health care services will be required to meet the increased demand.

Increases in Emergency Department utilization can be expected to continue. Current data shows that local Emergency Departments address more acute needs.

Ontario's Action Plan for Health Care states the government's commitment to build capacity in the community to reduce pressure on hospital emergency rooms and inpatient beds for those who could be better cared for at home or in the community, if the right supports are in place.

The Health System Plan, developed by the Central West LHIN in 2008, speaks to the LHIN's commitment to develop a strong foundation of integrated community-based services. The Health System Plan outlines the array of integrated community and hospital-based services to be developed in the Central West LHIN to the year 2019.

The Central West LHIN will be working with community providers to build capacity for services in the years to come. Focusing new resources into the community will support an increasing capacity to meet future health service demand.

New methods of health care funding are being used across the province. Growth pressures will be factored into new funding allocations. Health Service Providers will increasingly be rewarded for providing high quality services. The Central West LHIN will work closely with local Health Service Providers and the Ministry of Health and Long-Term Care to implement health funding reforms that improve service performance and improve access to services for local residents.

Facing a rapidly growing population and understanding local communities' plans for development, the Central West LHIN will continue to undertake analysis of service needs and resource capacity to improve access to local health care services. With a focus on examining the capacity of community-based services, this work will also include reviews of current plans for expanding hospital-based services as well as future needs beyond the March 31, 2016 end-date of this IHSP.

BSO – Behavioural Supports Ontario

Funded by the Central West LHIN, the BSO project was created to enhance services for elderly people with complex behaviours due to dementia, mental health or other neurological conditions. By allocating resources to Health Service Providers, the project provides services to seniors at home, in long-term care or wherever they live.

Granville Petgrave's family placed him in a long-term care facility that would better look after his growing needs as a result of dementia. They are particularly pleased with the treatment he's been getting under the BSO project.

"I'm glad to finally see the health care industry is paying attention to the elderly, especially people with dementia," says his son Steven. "My father has always been an independent person and this is very confusing for him."

Palliative Care Network

The Central West Palliative Care Network brings together health professionals and community based organizations to ensure the right supports are available at each stage of care for patients and their families.

Lynn Muir, a Manager with the Palliative Care Program at the Central West CCAC talks about how one client was able to spend his last days at Bethell House, with support from the Palliative Care Network. "The client died peacefully with his family at his bedside. The youngest daughter thanked the CCAC for the care as this journey went exactly the way the client had wished."

Use of Central West LHIN Health Care Providers by Residents of the LHINs

Because Ontario residents can choose where to get health care services, regardless of which LHIN they live in, residents in the Central West LHIN often receive care in hospitals outside the Central West LHIN. It is important to track where people are receiving their care in order to make planning decisions.

- For Acute Care, 64% of the care received by residents in the Central West LHIN was in hospitals in the Central West LHIN.
- For Emergency Department, 70% of the care received by residents in the Central West LHIN was in hospitals in the Central West LHIN.
- For Day Surgery & Cardiac Catheterization, 58% of the care received by residents in the Central West LHIN was in hospitals in the Central West LHIN.
- For Inpatient Mental Health, 71% of the care received by residents in the Central West LHIN was in hospitals in the Central West LHIN.
- For Inpatient Rehabilitation services, 34% of the care received by residents in the Central West LHIN was in hospitals in the Central West LHIN.

More patients are leaving Central West LHIN to receive care than are coming into the LHIN for their care. This is consistent with the activity in other GTA LHINs, where much of the patient flow is into the Toronto Central LHIN for specialized care and treatment at academic teaching hospitals.

The Central West LHIN has good data about those who use hospital services. While data is improving, the LHIN is not certain about the extent to which residents in the Central West LHIN use community-based services outside the LHIN, other than services provided by the Central West Community Care Access Centre (CCACs restrict services according to LHIN residency). Anecdotally, the Central West LHIN is aware that persons do leave the LHIN boundaries to seek community-based care, especially community-based mental health and addictions services.

Section E

The Focus Over the Next Three Years

The Integrated Health Service Plan is grounded by the LHIN's Mission, Vision and Values. All LHINs, including Central West LHIN, are focused on *creating a local health system that helps people stay healthy, delivers good care when needed and will be there for their children and grandchildren.*

Building on the LHIN's Mission, Vision and Values

Over the next three years, the Central West LHIN will focus its time and attention on four Strategic Directions: ***Improve Access to Care, Streamline Transitions and Navigation of the System, Drive Quality and Value and Build on the Momentum.***

The analysis performed during the development of IHSP 3 provides strong direction for LHIN activities. It includes measurable targets, like those outlined in the Ministry-LHIN Performance Agreement, so that performance can be reported over the life of the plan.

Because the IHSP is strategic – it does not cover everything – it is intentionally focused on those areas that the LHIN Board members and staff heard were the most important to the community, that are consistent with *Ontario's Action Plan for Health Care*, and that are expected to improve the health of residents in the Central West LHIN.

The strategic directions, which will guide both the initiatives and outcomes for the LHIN, reflect alignment with both *Ontario's Action Plan for Health Care* and the Pan-LHIN Imperatives. The Central West LHIN makes it its business to improve access and quality of health services for the people who reside in this LHIN. It is critically important to the Central West LHIN to foster

Because the IHSP is strategic... it is intentionally focused on those areas that the LHIN Board members and staff heard were the most important to the community, that are consistent with *Ontario's Action Plan for Health Care*, and that are expected to improve the health of residents in the Central West LHIN.

consistent behaviours. For this reason, the LHIN's values, person-centered, transparency, integrity and stewardship, play a central role in engaging the community, in communications, in planning and setting strategic directions, and relationships with Health Service Providers.

The LHIN also took into consideration the resources required to undertake the work stated in the IHSP 3. For this reason, initiatives which comprise the IHSP 3 were carefully chosen. They were chosen in such a way as to ensure that the LHIN had adequate time and resources to work on these initiatives.

The Central West LHIN has been very intentional about identifying initiatives that are aimed at meeting the Strategic Directions stated in the LHIN's third Integrated Health Services Plan. Measurable objectives will be determined on an annual basis and be outlined in the LHIN's Annual Business Plan. This way, the LHIN can monitor and manage progress towards achieving the Strategic Directions over the life of the IHSP 3 (April 1, 2013 to March 31, 2016).

The Strategic Directions in the Integrated Health Services Plan: 2013 to 2016

In its commitment to the four strategic directions, the LHIN identified strategic initiatives that the LHIN will pursue between 2013 and 2016.

I. Improve Access to Care

i. Improve access to Primary Health/Family Health Care

The LHIN will work with Family Health Teams (there are seven in the Central West LHIN) and other primary care practitioners to ensure that patients have timely access to multi-disciplinary primary care and that care is provided in appropriate settings as close to home as possible and to reduce avoidable visits to the emergency department. This work can be expected to reflect province-wide developments in improving models of care and the integration of primary care.

ii. Improve access to chronic disease prevention and management programs, with an emphasis on diabetes

The LHIN will work with community partners to increase capacity for self-management of chronic conditions, in order to improve treatment and management of chronic diseases in the community. This work will include the improved coordination of regional diabetes services to expand access to diabetes education and self-management programs for local residents.

iii. Improve access to mental health and substance abuse services, with a focus on youth

The LHIN will work with community partners to increase capacity for community-based programs and to improve early intervention for youth-at-risk. This work will align with Ontario's Comprehensive Mental Health and Addictions Strategy and its early focus on children and youth.

iv. Improve access to community-based services for seniors

The LHIN will work with funded community services to develop strategies to support seniors in the community and increase quality of life. This work will be aligned with the province's Seniors Care Strategy. This work will also aim at reducing avoidable emergency department visits, avoidable hospital admissions, and avoidable ALC designations.

II. Streamline Transitions and Navigation of the System

i. Improve linkages with and among Primary Health / Family Health Care and other providers in the health care system

The LHIN will increase coordination of CCAC care in primary care settings to ensure the provision of the right community-based care. The LHIN will work with providers to ensure that clients who do not have a primary care practitioner are assigned one upon discharge. The LHIN will focus on populations with complex needs, access care from multiple providers or are disadvantaged – marginalized and struggle to get the care they needs, when and where they need it.

ii. Improve system navigation resources

The LHIN will work with community-based and hospital-based providers to understand and address access barriers. The LHIN will work with providers to develop integrated care pathways and care plans to help people understand where and when to access the health care they need after being discharged from a hospital. The LHIN will partner with community and government agencies to strengthen system navigation and support the establishment and use of services, such as Healthline, which provide information about health care services and how to gain access to them.

iii. Increase system collaboration through use of information technologies

The LHIN will participate in provincial, regional and local initiatives to develop and establish information management and communications tools to share and access system and client information across services. Additionally, the LHIN will continue to facilitate the establishment of electronic medical record initiatives and other health record initiatives and work with hospitals and primary care practitioners to ensure timely discharge information is accessible by the primary care practitioners.

III. Drive Quality and Value

i. Ensure an overarching LHIN quality framework

The LHIN will support the establishment of education and training programs aimed at improving treatment, care and safety based on leading practices, while building capacity for improvement and safety. The LHIN will incorporate patient/client experience in quality indicators, develop a collaborative and integrated approach with Health Service Providers to support the development of quality improvement plans and support community-based Health Services Providers to undertake accreditation processes.

ii. Optimize use of health care resources to foster better value

The LHIN will reduce avoidable hospital admissions by supporting expanded community-based services. The LHIN will reduce Alternate Level of Care (ALC) designations by seeking improvements in discharge processes and supporting community-based services. The LHIN will work with local providers on the improvement of admission, bed utilization, and discharge processes. Additionally, the LHIN will implement Health Funding Reform initiatives with the Ministry of Health and Long-Term Care and local Health Service Providers to support best practice, cost-effective treatment and care.

IV. Build on the Momentum

The LHIN will continue to devote time, attention and resources to long-standing initiatives and activities, in keeping with the LHIN's legislated requirements, as they have been identified through community engagement and priority-setting over the past seven years, and aligned with developing provincial directions and priorities.

i. Aboriginal Health

The Central West LHIN will meet its legislated requirements to engage with local Aboriginal and First Nations peoples to better understand local health and service delivery issues and develop priorities and strategies to improve engagement and access to health care services.

ii. Diversity and Health Equity

The Central West LHIN will work with local Health Service Providers at the Diversity and Health Equity Core Action Group to identify specific local strategies to engage the diverse communities in the LHIN and to promote equitable access to health care services. This work will include identifying key priorities for action, utilizing tools such as the Health Equity Environmental Scan, the Health Equity Impact Assessment Tool (HEIA), Health Equity Plans, and focusing on culturally-competent approaches that improve access to, and the quality of, health care services.

iii. French Language Services

The Central West LHIN will meet its legislated requirements for coordinated and effective engagement of local French-speaking communities by working in collaboration with Reflet Salvéo, to foster a French Language Services lens across strategic directions to improve access to and integration of French language health care services in the local health care system.

iv. Palliative Care

Along with LHINs across the province and the Ministry of Health and Long-Term Care, and working locally with the Central West Palliative Care Network, the Central West LHIN will participate in the development of the vision for palliative care in the province and will establish the local plan for palliative care services, tailored to meet the needs of residents in the Central West LHIN.

v. Women and Children's Health

The Central West LHIN will work with local providers to improve access to and the quality of women and children's health services aligning its work with provincial initiatives.

The strategic directions, which will guide both the initiatives and outcomes for the LHIN, reflect alignment with both Ontario's Action Plan for Health Care and the Pan-LHIN Imperatives.

Strategic Directions and Initiatives

Mission

To improve access to, and the quality of, health services for residents of the Central West LHIN through strengthened integration and coordination of health services.

Vision

The Central West LHIN will work to create a local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren.

Values

Person-centred: We advance the public good with purpose and passion while honouring democratic values. We work with individuals and the community in pursuit of optimum health status. We are deeply committed to meeting the health care needs of our community and we constantly focus on client satisfaction.

Transparency: A commitment to the highest possible ethical standards, and open and timely sharing of information.

Integrity: In all of our activities, we will foster trust by being truthful, empathetic and consistent.

Stewardship: In managing all resources to which we have been entrusted, we will seek ways to ensure appropriate use of resources, and act responsibly, taking actions that align with our vision, values, and strategic directions.

	Strategic Directions		
Initiatives	**Improve Access to Care**	Streamline Transitions & Navigation of the System	Drive Quality and Value
	Improve access to Primary Health/Family Health Care • Work with Family Health Teams and other primary care practitioners to ensure that clients have timely access to multi-disciplinary primary care as close to home as possible • Provide care in appropriate primary care settings to reduce inappropriate hospital use	Improve linkages with and between Primary Health/ Family Health Care & other providers in the health care system • Increase coordination of CCAC care in primary care settings to ensure the provision of the right community-based care • Work with providers to ensure that clients who do not have a primary care practitioner are assigned one upon discharge • Focus on populations with complex needs, access care from multiple providers or are disadvantaged/marginalized and struggle to get the care they needs, when and where they need it	Ensure an overarching LHIN quality framework • Support the establishment of education and training programs aimed at improving treatment, care and safety based on leading practices • Build capacity for improvement and safety • Incorporate patient/client experience in quality indicators • Develop a collaborative and integrated approach with Health Services Providers to support the development of quality improvement plans • Support community-based Health Services Providers to undertake accreditation processes

Strategic Directions (continued)

Initiatives (continued)

Improve Access to Care

Improve access to chronic disease prevention and management programs, with an emphasis on Diabetes

- Work with community partners to increase capacity for self-management of chronic conditions to improve treatment and management of chronic diseases in the community
- Expand diabetes education and self-management programs for chronic diseases

Improve access to mental health & substance abuse services, with a focus on youth

- Work with community partners to increase capacity for community-based programs
- Work with community partners to improve early intervention for youth-at-risk

Improve access to community-based services for seniors

- Work with LHIN-funded community services to develop strategies to support seniors in the community

Streamline Transitions & Navigation of the System

Improve system navigation resources

- Work with community-based and hospital-based providers to understand and address access barriers
- Work with providers to develop integrated care pathways and care plans to assist people with navigating the system post-hospital discharge
- Partner with community and government agencies to strengthen system navigation
- Support the establishment and use of services such as Healthline which provide one-point information about health care services and how to access them

Increase system collaboration through use of information technologies

- Participate in provincial, regional and local initiatives to develop and establish information management and communications tools to share and access system and client information across services
- Continue establishment of electronic medical record initiatives and other health record initiatives, such as the integrated assessment records
- Work with hospitals and primary care practitioners to ensure timely discharge summaries and related information is accessible by the primary care practitioners

Drive Quality and Value

Optimize use of health care resources to foster better value for money

- Reduce avoidable hospital admissions by linking individuals with appropriate community-based services
- Reduce Alternate Level of Care (ALC) days by improving discharge processes and supporting alternate community-based services
- Improve admission, bed utilization, and discharge processes through education and communication
- Implement Health Funding Reform initiatives with the Ministry of Health and Long-Term Care and local Health Service Providers

Build on the Momentum: Aboriginal Health, Diversity and Health Equity, French Language Services, Palliative Care, Women and Children's Health

How Progress Will Be Measured

The following diagram illustrates and explains indicators for each initiative the LHIN will undertake during the timeframe of the LHIN's third Integrated Health Services Plan. These indicators are based on reliable and available data sources. The LHIN will regularly report on the progress of its work and share this on its website for the public and Health Service Providers to determine the LHIN's success.

Strategic Directions	Initiatives	Indicators	
Improve Access To Care • Building Capacity • Making resources available	**Improve access to Primary/ Family Health Care**	1. Proportion of eligible Central West residents referred to primary care by Health Care Connect within 30 days of request	Callers referred / Callers deemed eligible
		2. Rate of emergency visits (ER & urgent care centre) that could be managed elsewhere (conjunctivitis, cystitis, otitis media, upper respiratory infection)	Emergency visits for identified conditions / 1000 population
	Improve access to chronic disease prevention and management programs, with an emphasis on Diabetes	3. Rate of unscheduled emergency visits for hyperglycemia or hypoglycemia	ED visits for hypo- or hyperglycemia / All emergency department visits in the Central West LHIN
	Improve access to mental health & addictions services, with a focus on youth	4. Rate of ED visits in youths (aged 16-24) for mental health and substance abuse conditions	ED visits for Mental Health and Substance Abuse conditions / All emergency department visits
		5. Proportion of eligible Central West residents connected to mental health case management by Connex Ontario within 30 days of request	Callers connected within 30 days / Callers deemed eligible
		6. Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions **(MLPA #13)**	ED visits that followed another visit within 30 days for mental health or substance abuse conditions / ED visits for mental health conditions
		7. Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions **(MLPA #14)**	ED visits that followed another visit within 30 days for mental health or substance abuse conditions / ED visits for substance abuse conditions
	Improve access to community-based services for seniors	8. Avoidable admissions	Patients designated ALC within 2 days of admission / All patients designated ALC

How Progress Will Be Measeured (continued)

Strategic Directions	Initiatives	Indicators
Streamline Transitions and Navigation of the System • Improving handoffs • Seamless experience for consumers	Improve linkages with and between Primary / Family Health Care and other providers in the health care system	9. Percentage of ALC days for patients discharged from acute inpatient hospital beds **(MLPA #1)** — ALC days accumulated / Total hospital days accumulated
		10. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated **(CTAS IV-V)** Patients **(MLPA #4)**
	Improve system navigation tools	11. Proportion of low and moderate needs clients referred by CCAC to Community Support Services — Clients referred to Community Support Services / All low and moderate needs clients
		12. 90th Percentile Wait Time for CCAC In-Home Services from Community Setting **(MLPA #15)**
	Increase system collaboration through use of information technologies	13. Users that actively search the Integrated Assessment Record (IAR) — Users actively searching the IAR / Users who have logged into IAR
Drive Quality and Value • Quality/Patient Experience • Value (Economy, Efficiency, Effectiveness)	Support an overarching LHIN quality framework	14. % nosocomial infection indicators achieving target (clostridium difficile infection, ventilator-associated pneumonia, central line infections) — # Indicators achieving target / 3 indicators
		15. % falls indicators achieving target (In-hospital fractures from falls; Hospitalization for falls among Long Term Care Home residents) — # Indicators achieving target / 2 indicators
		16. % HSP's that have developed and implemented Quality Improvement Plans — # HSP's with Quality Improvement Plans / 53 HSP's
		17. % HSP's that are accredited — # accredited HSP's / 53 HSP's
	Optimize use of health care resources to better foster value	18. % Wait Time indicators achieving target (MLPA #5-11) — # Indicators achieving target / 6 indicators
		19. 90th Percentile Emergency Room Length of Stay for Non-Admitted Complex (CTAS I-III) Patients (MLPA #3)
		20. Readmission within 30 Days for Selected Case Mixed Groups (MLPA #12) — Patients discharged with specified case mixed groups readmitted to any facility for any non-elective patient care within 30 days of discharge for index admission / All discharges among the selected case mixed groups
		21. 90th Percentile Emergency Room Length of Stay for Admitted Patients (MLPA #2)

Section F

Continuing to Connect With the Local Community

Working Together:

The Central West LHIN will support coordination efforts across Health Service Providers to identify areas where coordination can support access to care, streamline transitions and navigation of the system and drive quality and value.

The Central West LHIN will continue to develop partnerships with other service providers in the broader health sector, including organizations and agencies that are focused on health promotion and prevention and on the many determinants of health. Working together, the LHIN and these partners can improve the health of the residents in the Central West LHIN.

The Central West LHIN was intentional about engaging the community, including residents in the Central West LHIN and local Health Service Providers, during the IHSP 3 process. Through that process the LHIN was able to listen to and learn from the perspectives of many individuals. Feedback on this process was positive and straightforward.

Consistent with its mandate, these efforts will continue as the LHIN moves forward in partnership with the local community and local Health Service Providers to improve access, integration and the performance of the local health care system.

The LHIN will ensure that there is broad and effective communication of the work the LHIN is undertaking to improve access to, and the quality of, health services for the residents of the Central West LHIN.

For more information visit our website

www.centralwestlhin.on.ca

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Central West **LHIN**
RLISS du Centre-Ouest

Integrated Health Services Plan 3
2013-2016